Specific Instructions for NC Medicaid Outpatient Treatment Report

How to complete NC Medicaid Outpatient Treatment Report for Area Programs/Contracted Providers

This is a six part form. Please ensure that each section is completed and legible. Upon completion of the form please fax it to Value Options at (919) 941-0433 or you may mail it to Value Options, Inc., P.O. Box 13907, RTP, NC 27709. **PLEASE DO NOT FAX AND MAIL YOUR FORMS** as such duplication may delay your request.

PATIENT DEMOGRAPHICS	
Patient's Name	Enter the Patient's first, middle and last name
Date of Birth	Enter the patient's DOB using month, day, year
Patient's Medicaid #	Enter the patient's Medicaid # as it appears on their Medicaid ID card
(if pending applied for)	If the patient does not yet have a Medicaid ID number but has applied for Medicaid, enter the date of the application for Medicaid on this line
Parent/Guardian Name	Enter the legal guardian's full name. If the legal guardian is DSS, enter DSS and Social Worker's name (if known)
Parent/Guardian Address	Enter the legal guardian's complete address. If DSS is legal guardian, enter DSS address
Parent/Guardian Phone Number: Home/ Work	Enter phone number (if available) for parent or legal guardian. If DSS is legal guardian, enter Social Worker's phone number

ASSESSMENT	
Symptoms	Look down the list of symptoms and for any symptoms that pertain to the patient, enter a rating on the line next to the applicable symptom (S=Same, B=Better, W=Worse). All blank lines are assumed to be absent. If you check Other, please write out the symptom and rate it as above.
Medications	Check whether or not patient has been evaluated for medications and check whether or not patient follows medication regimen.
Prescribing Physician	Enter Physician's name and also indicate if physician is the Primary Care Physician (PCP) or Psychiatrist.

ASSESSMENT (cont'd)	
Name of Medications	Enter name of medication, current dosage/frequency, the date the patient began taking the medication and check whether or not the patient is experiencing side effects.
Describe side effects/ Interventions	If you checked yes above under side effects, please enter the side effect and what steps have been taken to remedy or lessen the side effect (if any).

SERVICE PROVIDER DEMOGRAPHICS	
Name of Area Program	Enter the name of the Area Program or Contracted Provider providing services to the patient. A Contracted Provider is one who is contracted with the Area Program and bills through the Area Program or uses the Area Program's Medicaid provider number to bill for services.
Billing Address	Enter the complete address and phone number (including area code) where patient receives treatment
For Billing Purposes:	
Area Program/Contracted Provider Medicaid Number	Enter the Area Program's Medicaid Number or the Area Program number with the alpha character used by Contracted Providers to bill Medicaid
Federal Tax ID Number	Enter the Provider's Federal Tax ID Number

DIAGNOSES	
ICD-9 DX_____: **Axis I:_____-** **____;_____; _____**	Enter the ICD-9 diagnoses (It is okay to use the DSM-IV codes) AND the Axis I diagnoses **(Note: ICD-9 diagnosis is required for claims payment)**
Axis II: **Axis III:** **Axis IV:**	Enter the diagnoses for Axis II-IV if available
Axis V: Current GAF or CAFAS	Enter the Current diagnoses and either the GAF or CAFAS
Current Risk Assessment **Crisis Plan in Place:**	Please check all the risk assessments that apply to patient Check whether or not a crisis plan is in place and the date of the risk assessment
Other risk behaviors	Enter any other risk behaviors currently present

DIAGNOSES (cont'd)	
Last contact to coordinate Treatment: Behavioral/ Medical	Enter the last date (via phone, letter, or face-to-face) you worked on coordinating treatment for behavioral care (meaning coordination of care between any mental health providers) and enter the last date you worked on coordinating treatment for medical care (i.e. with a primary care physician). If not coordination of care has occurred, please write "none" in the date area.
Treatment Frequency & Duration:	
Date First Seen:	The date the patient was FIRST seen by the Area Program or Contracted Provider for the current condition for which they are being treated.
Date Last Seen:	The date the patient was LAST seen by the Area Program or Contracted Provider for the current condition for which they are being treated.
Projected Date of the 27th visit if patient is under 21	The date the provider anticipates the 27th visit will occur
Projected Date of the 9th visit if patient is 21 or older	The date the provider anticipates the 9th visit will occur **Note: During the first 8 visits only, group or family therapy (billed as CPT or Y-code) counts as ½ visit.**
Treatment Type	Check the applicable treatment type [(individual, group, family, other (explain)]. Value Options will authorize X number of visits using a generic code 90899 which will allow the CPT and Y codes billed to process correctly. Each CPT or Y code authorized as 90899 counts as one visit.
# Visits Requested	Enter the number of visits you are requesting for each CPT or Y code. Please ensure that you check eligibility (particularly end dates) as Value Options cannot authorize care beyond the patient's Medicaid eligibility end date.
Frequency	Enter the frequency of treatment for treatment type (i.e. number of visits per week; number of visits per months, etc.)
Estimated End Date	Enter the date provider anticipates treatment to end

At the bottom of the form you will find:

Treating Provider's Name:	Enter the name of the person who knows the most about the patient's current condition and treatment plan and the person responsible for answering clinical information about the patient.
Credentials	Enter the credentials (i.e. MD, LCSW, PhD, etc.) for the above person
Phone #	Enter the phone number where the above individual can be reached during working hours.
Date:	Enter the date the form is completed.

If you have any questions please contact Value Options Customer Service Department at **1-888-510-1150**.